UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

In Re:	)	
	)	
AREDIA and ZOMETA PRODUCTS LIABILITY LITIGATION (MDL No. 1760)	)	No. 3:06-MDL-01760 Judge Campbell/Brown
	)	
This Document Relates to All Cases	)	

O R D E R

A lengthy telephone conference was held with the parties in this matter on **August 22, 2006**. The conference was necessitated because the parties were unable to agree on Plaintiffs' Fact Sheet ("PFS") questionnaire. The Magistrate Judge has reviewed both parties' submissions and is not particularly enthused about either. The Defendant's is far too long and repetitive. The question only needs to be asked once, not multiple times. The Plaintiffs, on the other hand, are a bit stingy with the information they wish to provide. Consequently, the Magistrate Judge has not adopted either party's submission, but has gone through the Defendant's submission and eliminated some questions, reworded others, and retained others. A copy of the revised and approved PFS is attached to this Order. The Magistrate Judge feels that this is a balanced questionnaire which will give the Defendants a basis for beginning their defense of this matter. Both parties agreed on the release forms. The release forms submitted by the Defendant in Docket Entry 105, Attachment 2, are approved.

The parties need to keep in mind that questionnaires such as this have to be filled out initially by lay people.

Additionally, in this case, many of the Plaintiffs are quite ill or have since died and their cases are being handled by their personal representatives. This is why the Magistrate Judge has tried to reduce the legal jargon in many cases into plain English.

The Magistrate Judge hopes that the parties will keep this in mind in future discussions

The original Scheduling Order (Docket Entry 89, § (X)(B)) provides the PFS should be returned within forty-five (45) days of service of the PFS. Because of the delay in this matter, the time for responding is shortened to forty (40) days.

It is so **ORDERED**.

/s/ Joe B. Brown
JOE B. BROWN
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE AT NASHVILLE

IN RE: AREDIA® AND ZOMETA® PRODUCTS LIABILITY LITIGATION (MDL No. 1760)	**No. 3:06-MD-1760**
	JUDGE CAMPBELL
	MAGISTRATE JUDGE BROWN
This Document Relates To: ALL CASES	

PLAINTIFF'S FACT SHEET

Please provide the following information regarding yourself or each individual on whose behalf a personal injury or dental or other monitoring claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. Do not leave any questions unanswered or blank.

In filling out this form, please use the following definitions:

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon, pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) "**document**" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phonorecords, nonidentical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

You may attach as many sheets of paper as necessary to fully answer these questions. If you have any documents (as defined above), including, but not limited to, packaging, instructions, or other materials or items that you are requested to produce in response to questions in this fact sheet or that relate to Aredia®, Zometa®, or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint, **you must NOT** dispose of, alter or modify these

documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Name: _____
2. Civil Action No. in the United States District Court for the Middle District of Tennessee: _____
3. Name of court where the civil action was originally filed and Civil Action No. in that court: _____
4. Please provide the following for the principal attorney representing you.

_____
Attorney Name

_____
Firm

_____
Address

_____
Telephone Number Fax Number

_____
E-mail Address

B. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, an incapacitated person), please complete the following:

_____
Your Name

_____
Address

_____
Telephone number Fax Number

In what capacity are you representing the individual? _____

_____
If you were appointed by a court, please provide a copy of the order of appointment and state the:

_____
Court Date of Appointment

Your relationship to the deceased or represented person: _____

_____
If you represent a decedent's estate, state the date of the decedent's death:

_____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used Aredia® and/or Zometa®. Those questions using the term "You" refer to the person who used these medications or products. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

II. PERSONAL INFORMATION

A. Last name: _____
First name: _____
Middle name or initial: _____
Maiden name (if any): _____
Other names by which you have been known (from prior marriages or otherwise, if any): _____

B. Gender: Male _____ Female _____

C. Social Security number: _____

D. Driver's license number: _____
State of issuance: _____

E. Date and place of birth: _____

F. Racial/ethnic background: _____

G. Phone number: _____

H. Present home address: _____
_____

1. How long have you lived at this address? _____
2. Who has lived at this address with you and when? _____
_____
_____

I. Identify each prior home address where you have lived during the last twenty (20) years, including time periods of residence and persons, if any, who lived with you at each address and when:

Prior Address	**Dates You Lived At Address**	**Persons, If Any, Who Lived With You At Address And When**

J. Current or most recent employer:

_____
Name

_____
Address

_____
Phone number

_____
Dates of employment

_____

Occupation

_____

Description of responsibilities

K. All former employers in the past twenty (20) years (including military and self-employment):

_____

Name

_____

Address

_____

Phone number

_____

Dates of employment

_____

Occupation

_____

Description of responsibilities

[Attach additional sheets as necessary with the same information for any additional former employers.]

L. Have you ever served in any branch of the military?

Yes _____ No _____

If yes, answer the following questions:

1. Branch and dates of service: _____

_____

2. Have you been discharged from such service?

Yes _____ No _____

a. **If yes**, did you receive an honorable discharge?

Yes _____ No _____

b. Were you discharged for any reason relating to your medical, physical, psychiatric or emotional condition?

Yes _____ No _____

If yes, state what that condition was and who diagnosed it. _____

_____

3. Have you ever served overseas?

Yes _____ No _____

If yes, state the location(s) and date(s). _____

_____

M. Have you ever been rejected from military service for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, describe in detail the reason(s) you were rejected from military service. ___

_____

N. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. With whom the claim was filed: _____
4. The claim/docket number, if applicable: _____
5. Nature of the injury or disability claimed: _____

_____

6. Was compensation awarded? _____
   a. **If yes**, what was the payment period or period of disability? _____

   _____

   b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

   _____

   _____

   _____

[Attach additional sheets as necessary to describe all claims.]

O. Have you ever filed a Social Security disability claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. With whom the claim was filed: _____
4. Nature of the injury or disability claimed: _____

_____

5. Was disability awarded? _____
   a. **If yes**, what was the payment and period of disability? _____

   _____

   b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

   _____

   _____

   _____

[Attach additional sheets as necessary to describe all claims.]

P. Have you ever filed any other type of disability claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. Name of the insurer/employer or other party to whom the claim was made:

   _____

4. Nature of the injury or disability claimed: _____

   _____

5. Was disability awarded? _____

a. **If yes**, what was the payment and period of disability? _____

_____

b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

_____

_____

_____

[Attach additional sheets as necessary to describe all claims.]

Q. Have you ever been denied life insurance for reasons relating to your medical, physical, psychiatric or emotional condition?
Yes _____ No _____
If yes, please state when, the name of the company and the company's stated reason(s) for denial. _____

_____

_____

_____

R. Have you ever been denied medical insurance?
Yes _____ No _____
If yes, please state when, the name of the company and the company's stated reason(s) for denial. _____

_____

_____

_____

S. Have you ever brought a lawsuit against anyone aside from the present suit?
Yes _____ No _____
If yes, for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved.

_____

_____

_____

T. Have you ever made any other type of legal claim?
Yes _____ No _____

If yes, for each such legal claim, state (1) where the claim was filed (2) to whom the claim was submitted, if it was not filed (3) the caption or name of the claim, if any, (4) the names of the adverse parties, (5) the civil action or docket number assigned to the claim, if any, (6) a description of your claim, and (7) whether the claim has been resolved and if so, how it was resolved. _____

_____

_____

_____

U. Have you been convicted of a felony?
Yes _____ No _____
If yes, please identify the felony for which you were convicted, (1) when you were convicted, (2) where you were convicted, (3) whether you were incarcerated, and if so, for how long you were incarcerated. _____

_____

_____

_____

_____

_____

V. Has any insurance or other company provided medical coverage to you (either directly or through a group or employer) for the period beginning twenty (20) years before your alleged injury through the present?
Yes _____ No _____
If yes, then as to each such company, separately state:

1. Name of the company: _____
2. Address of the company: _____

   _____
3. The account/policy number or designation: _____
4. Dates of coverage: _____

W. Have you ever missed work for more than thirty (30) days for reasons related to your health?
Yes _____ No _____
If yes, please state the dates, employer and health condition. _____

_____

_____

_____

III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded. _____

_____

_____

_____

[Attach additional sheets as necessary.]

IV. FAMILY INFORMATION

A. Have you ever been married?
Yes _____ No _____

B. **If yes**, for each spouse/former spouse state:

1. Spouse's name: _____
2. Dates of marriage: _____
3. Spouse's date of birth: _____
4. Spouse's occupation: _____
5. Spouse's address and phone number: _____
_____
6. If applicable, why did the marriage end (*e.g.,* divorce, death)? _____
_____
7. If applicable, the date the marriage ended: _____
_____

C. Has anyone filed a loss of consortium claim in connection with your lawsuit regarding Aredia® and/or Zometa®?
Yes _____ No _____
If yes, identify who filed the loss of consortium claim. _____

D. Please provide the following information for your grandparents, parents, siblings and children:

Name	**Relationship to You**	**Date of Birth**	**Date of Death (if applicable)**	**Cause of Death (if applicable)**	**Occupation**

V. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer?
Yes _____ No _____

If yes:

1. When were you first diagnosed with cancer? _____
2. What type of cancer was it? _____
_____

B. Have you been diagnosed with cancer at any time since your first cancer

diagnosis (described above)?
Yes _____ No _____

If yes, please answer the following questions for EACH subsequent diagnosis: **[Attach additional pages as necessary]**

1. When were you diagnosed? _____
_____

2. What type of cancer was it? _____
_____

3. Was the cancer a recurrence of a prior cancer?
Yes _____ No _____

C. Please ensure that all of your diagnosing and treating physicians related to questions V (A) and (B), as well as their current contact information, are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

D. Have you ever experienced any of the following:

	Yes	No	Don't Know
Hypercalcemia?			
Spinal cord compression?			
Fractures or breaks of bones?			
Surgery or radiation to the bones in your body?			
Pain, ache or discomfort in your bones?			

E. If you answered "**yes**" to any of the conditions listed above, for each such condition: **[Attach additional pages as necessary]**

8. Please describe the condition and/or injury, including approximate dates.
_____
_____
_____
_____
_____

9. Please ensure that all of your diagnosing and treating physicians related to questions V (D) and (E), as well as their current contact information, are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

VI. DENTAL BACKGROUND

A. On average, during the twenty (20) year period BEFORE you used the drug(s) involved in this lawsuit, did you:

1. Brush your teeth per week? _____
2. Floss your teeth per week? _____
3. See a dentist for routine check-ups, examinations or teeth cleaning? _____

_____

_____

B. On average, during the period AFTER you used the drug(s) involved in this lawsuit to the present, do you:

1. Brush your teeth per week? _____
2. Floss your teeth per week? _____
3. See a dentist for routine check-ups, examinations or teeth cleaning? _____

_____

_____

C. Please describe the general condition of your teeth BEFORE you used the drug(s) involved in this lawsuit, including any missing, loose or extracted teeth, dental implants, dentures, bridges or other artificial fixtures, dental prosthodontics or orthodontia (including but not limited to, braces) or mouth guard usage.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

D. Please describe the general condition of your teeth AFTER you used the drug(s) involved in this lawsuit, including any missing, loose, or extracted teeth, dental implants, dentures, bridges or other artificial fixtures, dental prosthodontics or orthodontia (including but not limited to, braces) or mouth guard usage.

_____

_____

_____

_____

_____

_____

_____

E. At any time BEFORE the injury that you allege you have suffered occurred, had you ever experienced or been diagnosed with any of the following conditions:

	Yes	No	Don't Know
Osteonecrosis of the jaw			
Osteomyelitis			
Infection in the mouth			
Sinus infection			
Bone spurs in the mouth			
Exposed bone in the mouth			
Tooth decay			
Poor healing of infections in the mouth			
Gum disease or infection			
Periodontal disease			
Bleeding gums			
Grinding of the teeth			
Temporomandibular joint [TMJ] problems			
Dental pain			
Abscesses			
Lesions in the mouth			
Cancer of the mouth			
Herpes [in or around the mouth]			
Lockjaw			
Mandibular exostosis (bony outgrowth)			
Pain (persistent or otherwise) in the mouth or jaw			
Swelling in the mouth or jaw			
Non-healing sore in the mouth or jaw			
Draining fistula			
Numbness of the lip, chin, mouth or jaw			
"Heaviness" of the jaw			
Burning or tingling in the jaw			
Limited range of motion in the jaw			
Edentulous (toothless) regions in the mouth			

H. Please ensure that all of your dentists, oral and maxillofacial surgeons, orthodontists, periodontists, or other health care providers involved in providing dental care or treatment in the past twenty (20) years, along with their current contact information, are listed in the List of Medical and Other Health Care

Providers section of this packet (Pages 27-31).

VII. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? ***If yes***, please provide the first and last date on which you took the medication or substance. ***If you do not know*** *if you have used or taken any of the following medications or substances BEFORE the injury that you allege you suffered, write UNKNOWN in the Yes No boxes.*

		Yes	No	Date First Taken	Date Last Taken
1.	Corticosteroids a. Dexamethasone (Decadron)				
	b. Prednisone, methyl prednisone				
	c. Glucocorticosteroids				
	d. Other corticosteroids				
2.	Dental Anesthesia [including, but not limited to, Novocaine]				
3.	Radiation Therapy				
4.	Chemotherapy				
	a. 5-Fluorouracil (5-Fu, Adrucil) (IV)				
	b. Capecitabine (Xeloda) (oral)				
	c. Anthracyclines i. Doxorubicin (Adriamycin)				
	ii. Epirubicin (Ellence)				
	iii. EC (Doxorubicin Epirubicin/ cyclophosphamide)				
	iv. Mitoxantrone (Novantrone)				
	d. Bortezomib (Velcade)				
	e. Busulfan (Myleran, Busulfex)				
	f. Cyclophosphamide (Cytoxan)				
	g. "CMF therapy" (chemotherapy using the drugs Cyclophosphamide, Methotrexate (Amethopterin, Mexate, Folex, Rheumatrex, Trexall) and 5-Fluorouracil)				
	h. Dolasetron (Anzemet) (anti-nausea)				
	i. Estramustine (Emcyt, Estracyte)				
	j. Flutamide (Eulexin, Euflex)				
	k. Gemcitabine (Gemzar)				
	l. Interferon				

		Yes	No	Date First Taken	Date Last Taken
	m. Melphalan (Alkeran, L-PAM)				
	n. Thalidomide (Thalomid)				
	o. Vincristine (Oncovin, Vincasar PFS)				
	p. VAD (Vincristine, Adriamycin, Dexamethasone, cyclophosphamide)				
	q. Vinorelbine (Navelbine)				
5.	Hormonal Therapy (including, but not limited to, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
	a. Anastrozole (Arimidex)				
	b. Bicalutamide (Casodex)				
	c. Estradiol (Estrace, Climara, Estraderm)				
	d. Exemestane (Aromasin)				
	e. Flutamide (Eulexin, Euflex)				
	f. Fulvestrant (Faslodex)				
	g. Goserelin acetate (Zoladex)				
	h. Letrazole (Femara)				
	i. Leuprolide (Lupron, Eligard)				
	j. Megestrol (Megace)				
	k. Nilutamide (Nilandron)				
	l. Taxanes i. Docetaxel (Taxotere)				
	ii. Paclitaxel (Taxol, Abraxane)				
	m. Tamoxifen (Nolvadex)				
	n. Toremifene (Fareston)				
	o. Trastuzumab (Herceptin)				
6.	Blood Pressure (hypertension) Medication a. Amlodipine (Norvasc)				
	b. Bendrofluazide (Aprinox)				
	c. Diltiazem (Cardizem, Dilacor, Tiazac)				
	d. Perindopril (Aceon)				
	e. Verapamil (Calan, Verelan, Verelan PM, Isoptin, Covera-HS)				
	f. Other (describe: _____)				

	Yes	No	Date First Taken	Date Last Taken
7. Cholesterol-lowering Medication a. Atorvastatin (Lipitor)				
b. Simvastatin (Zocor)				
c. Other (describe: _____)				
8. Celecoxib (Celebrex)				
9. Diphenhydramine (Benadryl)				
10. Dutasteride (Avodart)				
11. Esomeprazole (Nexium)				
12. Ferrous Sulfate				
13. Hydroxychloroquine (Plaquenil)				
14. Isotretinoin (Accutane)				
15. Itraconazole (Sporanox)				
16. Leflunomide (Arava)				
17. Metformin (Glucophage)				
18. Morphine				
19. Omeprazole (Prilosec, Losec, Rapinex)				
20. Ranitidine (Zantac)				
21. Rosiglitazone (Avandia)				
22. Sertraline (Zoloft, Sertralin, Lustral, other)				
23. Sulfamethoxazole (Gantanol)				
24. Tramadol (Ultram)				
25. Trimethoprim (Bactrim)				
26. Warfarin (Coumadin, Marevan)				
27. Antidepressants				
28. Psychiatric Medications				
29. Cocaine/Crack Cocaine				
30. Heroin or Methadone				
31. Marijuana or Hashish				
32. LSD, Ecstasy, ICE, PCP				
33. Amphetamines				
34. Inhaled Nonprescription Substances (*e.g.*, inhalation of glue or toluene)				
35. Dietary Supplements, Vitamins				

		Yes	No	Date First Taken	Date Last Taken
36.	Herbal Products (describe:_____)				

B. Have you regularly taken any other prescription medicines in the last 10 years?
Yes _____ No _____
If yes, please list the medications, the first and last dates of ingestion, and reasons for taking each. _____
_____
_____
_____
_____
_____

C. Have you participated in any clinical trials or taken any experimental drugs?
Yes _____ No _____
If yes, please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs.
_____
_____
_____
_____
_____
_____
_____

D. Smoking History

1. Have you ever smoked cigarettes?
Yes _____ No _____ **If no, skip to D.4.**
2. Do you currently smoke cigarettes?
Yes _____ No _____
   a. **If yes**, state amount smoked: ____ packs per day for ____ years of the following brands of cigarettes: _____
   _____
   _____
   b. **If no**, state date on which smoking ceased _____ and state amount smoked: _____ packs per day for _____ years of the following brands of cigarettes: _____
   _____
   _____
   _____
3. At the time that you sustained the injuries alleged in the Complaint, did you smoke cigarettes?
Yes _____ No _____
If yes, state amount smoked: _____ packs per day for _____ years prior to date of the injury.

4. Have you ever smoked cigars or pipe tobacco?
   Yes _____ No _____ **If no, skip to D.7.**
5. Do you currently smoke cigars or pipe tobacco?
   Yes _____ No _____
   c. **If yes**, state amount smoked: _____ cigars/pipes per day for _____ years.
   d. **If no**, state date on which smoking ceased _____ and state amount smoked: _____ cigars/pipes per day for _____ years.
6. At the time that you sustained the injuries alleged in the Complaint, were you a smoker of cigars or pipe tobacco?
   Yes _____ No _____
   If yes, state amount smoked: _____ cigars/pipes per day for _____ years prior to date of the injury.
7. Have you ever dipped snuff/chewed tobacco?
   Yes _____ No _____
   e. **If yes**, state amount dipped/chewed: _____ cans/plugs per day for _____ years.
   f. **If no**, state date on which dipping/chewing ceased _____ and state amount dipped/chewed: _____ cans/plugs per day for _____ years.

E. Drinking History
1. Do you currently drink alcohol (beer, wine, whiskey, etc.)?
   Yes _____ No _____
   If yes, check which represents your current alcohol consumption
   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week
   _____ Other (Describe: _____)
2. Have you ever drunk alcohol (beer, wine, whiskey, etc.)?
   Yes _____ No _____
   If yes, please check which represents your greatest alcohol consumption over an extended (six (6) months or greater) period within the last 20 years?
   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week
   _____ Other (Describe: _____)
   When was this period? _____
3. Check which represents your weekly alcohol consumption during the period you commenced taking you first used the used the drug(s) you allege caused your injury in this case through the onset of your alleged injury.
   _____ 0 drinks per week
   _____ 1-5 drinks per week

_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (Describe: _____)

F. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	No	Don't Know
1. Necrosis, avascular necrosis, or osteonecrosis in any part of the body			
2. Osteomyelitis			
3. Diseases of the jaw or oral cavity			
4. Osteoporosis			
5. Paget's disease			
6. Pancytopenia secondary to cancer and/or cancer treatment			
7. Sickle cell disease			
8. Gaucher's disease			
9. Leiden mutation of the factor V gene			
10. Coagulation or clotting abnormalities or disorders, such as blood clots or thrombosis			
11. Abnormality of blood vessels or circulatory system			
12. Hyperlipidemia and lipid disorders, such as but not limited to high cholesterol			
13. Autoimmune or connective tissue disorders			
a. Systemic lupus erythematosus			
b. Rheumatoid arthritis			
c. Vasculitis			
d. Other (describe: _____)			
14. Other rheumatological condition (describe: _____)			
15. Acquired Immunodeficiency Disease Syndrome (AIDS) or HIV			
16. Vascular insufficiency			
17. Renal transplant/disease			
a. Renal impairment			
b. Renal disease			
18. Caisson's disease/barotrauma			
19. Pancreatitis			
20. High blood pressure or hypertension			
21. Arterial disease			
22. Peripheral vascular disease			
23. Infection			
24. Diabetes Mellitus			

	Yes	No	Don't Know
25. Fungal infections (including, but not limited to, Aspergillis fungus)			
26. Fibrous Dysplagia			
27. Secondary hyperparathyroidism/hypocalcemia			
28. Local ischemia			
29. Hypoproteinemia			
30. Hyperviscosity syndrome			
31. Anemia or leucopenia			
32. Thrombocytopenia			
33. Thrombophilia or hypofibrinolysis			
34. Asthma			
35. Blood disorders or dyscrasias			
36. Persistence of low serum calcium levels (hypocalcemia)			
37. Persistence of high serum parathyroid levels (hyperparathyroidism)			

G. If you responded "**yes**" to any of the above, please identify the condition and the date of onset: **[Attach additional sheets as necessary until all listed conditions have been described.]** Additionally, please ensure that all of your diagnosing and treating physicians related to questions VII (A), (B), and (F), as well as their current contact information, are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

1. Condition: _____
   Date of onset: _____

2. Condition: _____
   Date of onset: _____

3. Condition: _____
   Date of onset: _____

H. Have you experienced or been treated for any psychological, psychiatric, or emotional problems (including depression) in the past twenty (20) years?

If yes, please provide the following information for each condition:

1. Describe the symptoms experienced. _____
   _____

2. Describe the condition treated. _____
   _____

3. Please ensure that all of your diagnosing and treating physicians, as well as any facilities or hospitals where treatment was provided, related to question VII (H),are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

I. Have you ever suffered any traumatic injury to your head neck, mouth or jaw?
Yes _____ No _____
If yes, please state:
1. When the injury occurred:
2. The nature of the injury, including what body part was injured.

_____

_____

_____

3. Please ensure that all of your diagnosing and treating physicans, as well as any facilities or hospitals where treatment was provided, along with their current contact information, related to question VII (I) are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

J. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

	Yes	No	Don't Know
1. Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging			
2. Dental x-rays, panorexes, or other dental imaging			
3. Echocardiogram			
4. Electrocardiogram			
5. Electroencephalogram			
6. Magnetoencephalography			
7. Arteriogram or angiogram			
8. MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans or x-ray			
9. MRA (magnetic resonance angiography)			
10. Doppler scans			
11. Ultrasound			
12. PET scans			
13. Biopsies			
14. Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures			
15. Other diagnostic test or imaging of the mouth or jaw			
16. Stem cell or organ transplant			
17. Prehematopoietic stem cell transplantation			
18. Vascular surgery			
19. Any other surgery (describe):_____			

L. Please ensure that all of your diagnosing and treating physicans, as well as any facilities or hospitals where treatment was provided, related to question VII (J) are listed in the List of Medical and Other Health Care Providers section of this packet (Pages 27-31).

VIII. AREDIA®, ZOMETA®, AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

	Yes	No	Don't Know
Aredia®:			
Zometa®:			
Fosamax®:			
Actonel®:			
Boniva®:			
Didronel®:			
Skelid®:			
Ostac®:			
Bonefos®:			

B. Complete the following information for each drug identified above:

Dates of Use of Drug	**Dosage**	**Physician Who Prescribed**	**Address of Prescribing Physician**	**Condition(s) Treated**	**Name and Street Address of Location Where Drug Was Infused, Injected or Taken**

C. For what disease or condition were you prescribed each of the medications identified in sections (A) and (B) above:

1. Injury, illness, or disability: _____
2. Date(s) of onset: _____
3. Date(s) of diagnosis: _____
4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

_____

_____

_____

_____

5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability. _____

_____

D. At the time you first began taking Aredia®, Zometa®, or other bisphosphonates did you suffer from any other physical injuries,

illnesses or disabilities other than the disease or condition identified in VII above?

Yes _____ No _____

If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis

1. Injury, illness, or disability: _____
2. Symptom(s): _____
3. Date(s) of onset: _____
4. Date(s) of diagnosis: _____
5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

IX. THE INJURY

A. Please briefly describe the nature of the injuries for which you are seeking compensation **[Attach additional sheets as necessary]**._____

X. DAMAGE CLAIMS

A. Complete the following information with respect to your employment for ten (10) years prior to your alleged use of Aredia® and/or Zometa® to the present.

Employer	Address	Type of Business/ Position	Dates of Employment	Salary	Overtime	Bonus

B. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of Aredia® and/or Zometa® and the amount of income which you lost.
Total time _____days
Total income lost $ _____

C. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of Aredia® and/or Zometa® for which you seek recovery in the action which you have filed?
Yes _____ No _____
If yes, please state the total amount of such expenses at this time.
$ _____

D. If you are making any claims for other out-of-pocket expenses, please complete the following:
1. For what expenses? _____
2. Amount of fees or expenses: _____

E. Please identify all persons who you believe possess information concerning your injury, your current medical condition, the underlying cancer or illness for which you took Aredia® and/or Zometa®, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess. This does not include any healthcare providers you have listed in response to the List of Medical and Other Health Care Providers section of this packet (Pages 27-31)._____
_____
_____

_____

_____

_____

_____

_____

XI. DOCUMENTS

Please attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental, or mental condition at any time, produce an executed copy of the release form attached to this Plaintiff's Fact Sheet as Ex. A, authorizing NPC to obtain medical records from each health care practitioner.

B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from each health care practitioner who later becomes known to NPC who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental, or mental condition at any time.

C. For each hospital, clinic or any other facility at which you have been treated for any medical, dental, or mental condition at any time, produce an executed copy of the release form attached as Ex. A, authorizing NPC to obtain medical records from each such hospital, clinic or any other facility.

D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from any hospital, clinic or any other facility that later becomes known to NPC and at which you have been treated for any medical, dental or mental condition at any time.

E. For each health care practitioner, who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at any time, at or in affiliation with a Veteran's Administration facility, produce an executed copy of the release form attached as Ex. B, authorizing NPC to obtain medical records from each health care practitioner.

F. For each health care practitioner, who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at any time, produce an

executed copy of the release form attached as Ex. C, authorizing that person to review your medical records, participate in informal *ex parte* communications with NPC's attorneys, and give testimony regarding your medical condition.

G. For each psychologist, psychiatrist or other mental health care practitioner who has examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Aredia® and/or Zometa®, produce an executed copy of the release form attached as Ex. D, authorizing NPC to obtain your psychotherapy notes generated by any such mental health care practitioner.

H. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the years from three (3) years prior to your injury to the present.

I. Produce executed copies of each of the authorizations, attached as Ex. F, authorizing NPC to obtain your Federal and State income tax returns for each of the years from three (3) years prior to your injury to the present.

J. Produce executed copies of each of the authorizations, attached as Ex. G, authorizing NPC to obtain your earnings information from the Social Security Administration

K. For each of your prior employers, produce two executed copies of the release form attached as Ex. H, permitting NPC to obtain your employment records, including W-2 forms.

L. For your current employer, produce two executed copies of the release form attached as Ex. H, permitting NPC to obtain your employment records, including W-2 forms.

M. If you have served in the military, produce an executed copy of the release form attached as Ex. I, permitting NPC to obtain your military personnel, service, and health records.

N. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Aredia® and/or Zometa®.

O. Copies of advertisements, videos, written materials or promotions for Aredia® and/or Zometa® which you saw prior to use of the drug(s).

P. All documents relating to Aredia® and/or Zometa® or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint.

Q. All documents you (and not your lawyer) obtained directly or indirectly from NPC.

R. Any diary, calendar or any other writing or recording made by you, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint, not including those items covered by Attorney-Client Privilege.

S. Any diary, calendar or any other writing or recording made by you, describing, discussing, explaining or referring to the underlying illness or disease for which you received Aredia® and/or Zometa®, not including those items covered by Attorney-Client Privilege.

T. Copies of all documents you (and not your attorneys) obtained from any source related to Aredia® and/or Zometa® or to the alleged effects of such medications, not including those items covered by Attorney-Client Privilege.

U. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

V. Decedent's death certificate (if applicable).

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part XI of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____

Signature/Date

IN RE: AREDIA AND ZOMETA PRODUCTS LIABILITY LITIGATION

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF TENESSEE

MDL NO. 1760

LIST OF MEDICAL AND OTHER HEALTH CARE PROVIDERS

AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL AND OTHER HEALTH CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

A. Identify your current primary care physician(s):

_____

Name

_____

Street Address

_____

City, State, Zip Code

B. Identify each of your primary care physicians for the 20 years prior to your use of Aredia® and/or Zometa® through the present.

_____

Name

_____

Last known address

_____

Approximate dates physician was primary care physician for you

_____

Name

_____

Last known address

_____

Approximate dates physician was primary care physician for you

_____

Name

_____

Last known address

_____

Approximate dates physician was primary care physician for you

[Attach additional sheets if necessary.]

C. Identify each dentist, oral and maxillofacial surgeon, orthodontist, periodontist, or other health care provider involved in providing dental care or treatment who has ever seen or treated you.

1. _____
Name

_____
Last known address

_____
Specialty

_____
Approximate dates of treatment

2. _____
Name

_____
Last known address

_____
Specialty

_____
Approximate dates of treatment

3. _____
Name

_____
Last known address

_____
Specialty

_____
Approximate dates of treatment

[Attach additional sheets if necessary.]

D. Identify each oncologist or other health care provider involved in the treatment and medical care for cancer, or the underlying illness for which you took Aredia® and/or Zometa®, whom has ever seen or treated you.

1. _____
Name

_____
Last known address

_____
Specialty

_____
Approximate dates of treatment

2. _____
Name

_____
Last known address

_____
Specialty

_____

Approximate dates of treatment

3. _____
Name

_____
Last known address

_____
Specialty

_____
Approximate dates of treatment

[Attach additional sheets if necessary.]

F. Identify each hospital or healthcare facility where you have received treatment (including, but not limited to outpatient treatment or treatment in an emergency room) during the 20 years prior to your treatment with Aredia® and/or Zometa® through the present.

1. _____
Name

_____
Address

_____
Approximate dates of treatment

2. _____
Name

_____
Address

_____
Approximate dates of treatment

3. _____
Name

_____
Address

_____
Approximate dates of treatment

[Attach additional sheets if necessary.]

G. Identify each other physician, dentist or healthcare practitioner whom you have seen or are currently seeing for examination evaluation, diagnosis or treatment of any condition, injury, physical infirmity, disability, sickness, ailment, or affliction.

1. _____
Name

_____
Address

_____
Specialty

_____
Approximate dates of treatment

2. _____
Name

Address

Specialty

Approximate dates of treatment

3. Name

Address

Specialty

Approximate dates of treatment

[Attach additional sheets if necessary.]

H. Identify each pharmacy, drugstore or place where you have had prescriptions filled during the 20 years prior to your use of Aredia® and/or Zometa® through the present.

1. Name

Address

Approximate dates

2. Name

Address

Approximate dates

3. Name

Address

Approximate dates

[Attach additional sheets if necessary.]

I. Identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the 20 years prior to your use of Aredia® and/or Zometa®, or other bisphosphonates through the present:

1. Name

Address

Specialty

Approximate dates of treatment

2. _____
Name

_____
Address

_____
Specialty

_____
Approximate dates of treatment

3. _____
Name

_____
Address

_____
Specialty

_____
Approximate dates of treatment

[Attach additional sheets if necessary.]